VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 20, 2010

Mary Hagarty, Director
VNA & Hospice Of SVHC
160 Benmont Avenue Suite 17
Bennington, VT 05201

Provider ID #: 477017

Dear Ms. Hagarty:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 14, 2010**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
Assistant Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477017	A. BUILDING _____ B. WING _____	07/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA & HOSPICE OF SVHC	160 BENMONT AVENUE SUITE 17 BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An unannounced Federal recertification survey and extended survey was conducted from 7/12/10 through 7/14/10 by the Division of Licensing and Protection. As a result of the Home Health Agency survey, the Agency is not compliance with the Condition of Participation for Compliance with Federal, State and Local Laws, Disclosure and Ownership Information, and Accepted Professional Standards and Principles.	G 000	G 117 The Agency response to this condition is included in response to G 121.	RECEIVED Division of AUG 12 10 Licensing and Protection
G 117	484.12 COMPLIANCE W/ FED, STATE, LOCAL LAWS This CONDITION is not met as evidenced by: Based on information obtained through staff interviews and record review the the Home Health Agency failed to assure nursing staff complied with the agency's Suicide Prevention Policy and failed to maintained professional standards of practice.	G 117	G117 POC accepted 8/10/10 Karen Campos RN	
G 121	Refer to Tag G121 Standard: Compliance With Accepted Professional Standards and Principles 484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on interview and record review, the Home Health Agency (HHA) failed to assure nursing	G 121	G 121 starts on page 2.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 8.11.10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

G 121 The Agency requests that this deficiency be withdrawn for the following reasons:

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G 121	Continued From page 1 staff complied with the agency's Suicide Prevention Policy and maintained professional standards of practice for 1 applicable client. (Patient #1) Findings include: 1. Per review on 7/12/10 of the agency's call log, Patient #1, who has a diagnosis of depression, anxiety and physical impairments and lives alone, had contacted the HHA answering service on Sunday, 6/20/10 with a "mental health issue." Per review of a "Chart work on call" note dated 6/20/10 the nurse responsible for call writes: "Contact notes: [Patient #1] called nurse on call reporting that [s/he] is having suicidal ideations. [S/he] reports that [s/he] was advised by MD on call...call 911. This nurse offered to call United Counseling hot line number. [Patient #1] voiced grief over loss of husband 16 years ago and frustration on not being able to get beyond it...At end of conversation [Patient #1] admitted that [s/he] needed to go to ER because thoughts not going away and [s/he] needed some help. [S/he] voiced that [s/he] would call 911 via life line." Per review of the agency "Suicide Prevention Policy" (revised 12/09) it states "when a patient speaks of suicide, the issue will be taken seriously and appropriate intervention will occur." In order "to ensure the safety of a potentially suicidal patient", the policy requires that staff "..must call 911; call United Counseling Service...request the crisis intervention team ASAP...; call the patient's primary physician and call...immediate supervisor or supervisor on call." Per interview on 7/13/10 at 8:40 AM, the nurse who received the call from Patient #1 confirmed s/he did not call 911, stating s/he was relying on the patient to use his/her Lifeline call button. The	G 121	**G 121** The Agency requests that this deficiency be withdrawn for the following reasons: 1. The Agency's policy on suicide prevention in effect at the time of the survey did not require staff to call 911 in all instances in which patients threatened suicide or experienced suicide ideation. Instead, the Agency's policy in effect at the time of the survey required staff to call 911 only if patients were in imminent danger. 2. An investigation conducted by the Administrator indicates that Patient #1 called her physician before calling the Agency's nurse on call. Patient #1 also rejected offers from the nurse on call to call her physician, 911, and United Counseling Services. Patient #1 stated to the nurse on call that she knew she needed help and stated that she would contact 911 herself. These actions made it clear that Patient #1 was not in imminent danger because she sought appropriate assistance prior to contact with the nurse on call and without intervention from Agency staff. Nonetheless, the Agency has taken the following corrective action: 1. The Agency has revised the Policy on Suicide Prevention. A copy of the Agency's Policy on Behavioral Emergencies is attached to this Plan of Correction (POC) as Exhibit 1. Continued on page 3.	

Executive Director 8-11-10

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G 121	Continued From page 2 nurse also confirmed s/he failed to call United Counseling and suggested the patient contact the crisis intervention team; however, Patient #1 informed the nurse s/he did not want to contact the crisis service. In addition, the nurse failed to notify Patient #1's primary physician and failed to call the supervisor on-call with notification of the event. The nurse stated s/he did not make a follow-up call to Patient #1 to verify the patient actually used their Lifeline button to summons 911. The nurse also confirmed there was no consideration to have a staff member make a home visit or to remain on the phone with Patient #1 while the patient activated the Lifeline and confirmed emergency services would be arriving to the patient's home. The nurse did state s/he had contacted the Emergency Department (ED) within the hour and did verify that Patient #1 was admitted to the ED. However, the nurse failed to document in the note a call was made to the ED and who confirmed Patient #1 was receiving treatment. Per interview on 7/14/10 at 1:20 PM, the on-call nursing supervisor confirmed s/he was not notified by the nurse regarding Patient #1's suicidal ideation and admission via 911 to the ED. The nursing supervisor stated "...notification means paging" and s/he did not receive a page but did confirm the nurse had included, via voicemail report at completion of weekend call, a message that Patient #1 was transferred to the ED. Later the agency was notified Patient #1 was admitted to a psychiatric unit requiring treatment for 7 days for Suicidal Ideation. Per interview on 7/14/10 at 11:35 AM, the Director of the HHA confirmed the nurse failed to follow the agency "Suicide Prevention Policy".	G 121	2. The Administrator is responsible to ensure that documentation of all behavioral emergencies is completed and reviewed to assess whether appropriate action was taken. 3. Agency staff members who fail to complete documentation of behavioral emergencies promptly, who do not notify their immediate supervisors or supervisors on call as soon as possible, or who do not take appropriate action will be counseled. Other disciplinary action will be taken, if appropriate. Documentation of counseling and other disciplinary action, if taken, will be placed in staff members' personnel files. 4. The Administrator will conduct a mandatory in-service program for all staff on August 11, 2010, to review the Policy on Behavioral Emergencies. Attendance will be documented using a sign-in sheet. G121 POC accepted 8/12/10 Karen Campos RN	8/11/10

Executive Director 8.11.10

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G 121	Continued From page 3 In addition to not following the agency policy and procedure, the nurse failed to maintain professional standards by not assessing potential risk factors associated with Patient #1 to include: Patient's associated psychiatric diagnosis of Depression, experienced loss, socially isolated, preoccupation with husbands death, and whether the patient had a specific plan for suicide. Reference: Lippincott Manual of Nursing Practice (9th Edition) Wolters Kluwer Health/Lippincott Williams & Wilkins: Chapter 35 Emergent Conditions: Behavioral Emergencies: Pages: 1222 and 1223; Standards of Professional Nursing Practice: Standards of care, page 17.	G 121		
G 142	484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.	G 142	**G 142** The Agency has taken the following corrective action: 1. The Agency has reviewed all existing contracts and prepared a current list of contracts. A copy of this list is attached to this POC as Exhibit 2. 2. The Agency has determined that there are no hourly or per visit contracts currently in effect to provide home health services. MGH 3. If the Agency enters into any hourly or per visit contracts in the future, the Administrator will ensure that the requirements of 484.14(f) are met.	

Executive Director 8.11.10

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G 142	Continued From page 4 This STANDARD is not met as evidenced by: Based on review of agency contracts and confirmed through interview with the administrative staff, the agency failed to assure all contracts were kept current for 1 of 5 contracted services in the targeted sample. Findings include: 1. Per record review on the afternoon of 07/14/10, 1 of 5 business contracts were outdated as of 02/08/10. In addition, a master list of contracts showed several of them as being expired. Per interview on 7/14/10 at 3:15 PM, the Director of Health Care Services Assessment stated "the [new] system (for assuring contracts are current) is not up to where it should be" and confirmed that the contracts were not current.	G 142	G 142 POC accepted 8/10/10 Karen Campoli RN **G 166** The Agency has taken the following corrective action: 1. The Administrator conducted and completed an investigation to determine why a verbal order in Patient #2's chart was not signed by the physician. Based upon her investigation, the Administrator concluded that the software used by the Agency to create an electronic record of care provided to patients required staff to indicate whether or not copies of verbal orders should be printed and sent to physicians. With regard to the verbal order cited in the deficiency, the staff member did not choose the option that would cause a copy of the verbal order to be printed and sent to the physician.	
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and interview, the Agency failed to have verbal orders signed by the physician for 1 applicable patient in the sample (Patient # 2). Findings include: 1. Per review on 07/13/10 of Patient #2's electronic and hard copy clinical record, a verbal order was not signed by the physician. The	G 166	2. Based on her investigation, the Administrator instructed the Agency's staff person responsible for IT to change the software used by the Agency so that verbal orders are automatically printed and sent to physicians for signature. The settings on the laptop computers of all staff will be modified to effect this change on or before August 11, 2010. The Administrator is responsible for implementation. Continued on page 6.	8/11/10

Executive Director 8-11-10

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G 166	Continued From page 5 verbal order, initiated by the physical therapist on 12/10/09 for physical therapy visits 1-2 times a week for 4 weeks, was found in the electronic record; however, a copy countersigned by the physician was not found. Per interview on 7/14/10 at 10:45 AM, the Clinical Coordinator confirmed the verbal order was not sent to the physician to be signed.	G 166	G166 POC accepted 8/18/10 Karen Campos RN 3. The Administrator has assigned the responsibility for Follow up on M&M verbal orders sent to physicians are signed and returned to internal administrative staff, namely the Administrative Assistant to the Executive Director and/or the Medical Records clerk. The Administrator will monitor the performance of this function on a weekly basis. Patty Andrews, Marie Hoffman MED 4. The IT staff person and the Administrator will periodically check to make certain that the software is functioning as described above. 5. The Administrator is responsible to ensure that final claims are not submitted to the Medicare Program until all verbal orders have been signed by physicians. The Administrator will review reports of pre-billing reviews on a weekly basis and document that she has done so.	
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, a HHA nurse failed to complete documentation regarding a patient emergency and failed to inform the physician and other personnel of changes in the patient's condition for 1 applicable patient (Patient #1). Findings include: Per interview on 7/13/10 at 8:40 AM, a HHA nurse confirmed the "chart work on call" notes completed on 6/20/10 did not include documentation regarding any follow-up communication made to the Emergency Department after Patient #1 was emergently brought to the ED for suicidal ideation. The nurse also confirmed s/he failed to notify Patient #1's physician after the patient requested emergency intervention for suicidal ideations and was subsequently transported to the Emergency Department for crisis screening.	G 176	G176 POC accepted 8/19/10 Karen Campos RN	
G 243	484.52 EVALUATION OF THE AGENCY'S PROGRAM	G 243		

Executive Director 8.11.10

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G 243	Continued From page 6 The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. This STANDARD is not met as evidenced by: Based on interview and record review, there was a failure to have the annual evaluation of the Agency's total program evaluated by professional personnel or consumers. Findings include: 1. Per review on 7/14/10 of the Home Health Agency's (HHA) programs, services and processes, a management team of the HHA's 6 managers/coordinators compiled the results for the Year End Agency Evaluation for 2009. Per the Managers Meeting minutes, dated 10/16/09, the Hospital Safety/QA committee did not receive or review the evaluation, nor was there evidence that a consumer was represented for the annual evaluation. Per interview on 07/15/10 at 5:45 PM the Director of Health Care Services and the Administrator confirmed that neither the Safety committee (professional group) nor a consumer contributed to the Agency's annual evaluation.	G 243	see attached addendum - accepted K.Campos **G 176** The Agency has taken the following corrective action: 1. The Agency has revised the Policy on Suicide Prevention. A copy of the Agency's Policy on Behavioral Emergencies is attached to this Plan of Correction (POC) as Exhibit 1. 2. The Administrator is responsible to ensure that documentation of all behavioral emergencies is completed and reviewed to assess whether appropriate action was taken. 3. Agency staff members who fail to complete documentation of behavioral emergencies promptly, who do not notify their immediate supervisors or supervisors on call as soon as possible, or who do not take appropriate action will be counseled. Documentation of counseling will be placed in staff members' personnel files. 4. The Administrator will conduct a mandatory in-service program for all staff on August 11, 2010, to review the Policy on Behavioral Emergencies. Attendance will be documented using a sign-in sheet.	8/11/10

Executive Director 8.11.10

G 243

The Agency has taken the following corrective action:

1. The Agency's Policy on Review and Revision has been revised so that review is no longer required by the Hospital's Safety and Quality Committee. A copy of the revised Policy is attached to this POC as Exhibit 3.

2. The PAC met on August 2, 2010 and approved the evaluation for 2009. Copies of the Agenda for this meeting, the minutes of this meeting, and the evaluation are attached to this POC as Exhibit 4.

3. A complete list of the members of the PAC is attached to this POC as Exhibit 5. The PAC includes a consumer member, whose name is Eileen Rice.

Submitted: 8-19-10

G243 POC accepted 8/19/10

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H 001	Initial Comments An unannounced annual State Designation recertification survey was conducted 07/12/10 - 07/14/10 by the Division of Licensing and Protection.	H 001		
H 645 SS=C	6.12(a) Organization, Services and Administration VI. Organization, Services and Administration 6.12 A home health agency shall keep a log of all complaints. The log shall include the date of the complaint, name of complainant, subject of the complaint, person assigned and the date and resolution of the complaint. (a) The home health agency shall respond to all complaints, whether received orally or in writing, within 2 business days. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview, the Home Health Agency failed to maintain a complaint log and failed to develop a policy which included a correct response time to all complaints received orally or in writing. Findings include: Per review on the afternoon of 7/14/10 of the Agency's complaint process, it was confirmed by both the Agency Director and the Director of Health Care Services Assessment that a complaint log has not been developed by the Agency. Per review of the "Complaint Resolution Procedure for Patient Complaints" (effective date 3/2/10), it does not address requirements specific to the Regulations for the Designation and Operation of Home Health Agencies, which	H 645	<u>H 645</u> The Agency has taken the following corrective action: 1. The Agency's policy on complaints has been revised. A copy of the revised policy entitled Agency Complaint Resolution is attached to this POC as Exhibit 6. The revised Policy requires the Agency to develop and utilize a log for complaints. 2. The Administrator will review the log monthly to ensure compliance with the Agency's revised Policy and document that she has done so. H645 POC accepted 8/19/10 Karen Campos RN	RECEIVED Division of AUG 12 10 Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Executive Director TITLE (X6) DATE 8.11.10

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H 645	Continued From page 1 require a response to all complaints within 2 business days. Per Agency policy: "The complainant will be contacted to acknowledge receipt of the concern and to obtain further information if necessary. If unable to respond immediately, the complainant is to be advised that there will be a response from the organization within 5 business days."	H 645	**G 1612** The Agency has taken the following corrective action: 1. The Administrator conducted and completed an investigation to determine why a verbal order in Patient #2's chart was not signed by the physician. Based upon her investigation, the Administrator concluded that the software used by the Agency to create an electronic record of care provided to patients required staff to indicate whether or not copies of verbal orders should be printed and sent to physicians. With regard to the verbal order cited in the deficiency, the staff member did not choose the option that would cause a copy of the verbal order to be printed and sent to the physician. 2. Based on her investigation, the Administrator instructed the Agency's staff person responsible for IT to change the software used by the Agency so that verbal orders are automatically printed and sent to physicians for signature. The settings on the laptop computers of all staff will be modified to effect this change on or before August 11, 2010. The Administrator is responsible for implementation. Continued on page 3.	
H1612 SS=D	16.7(f) Plan of Care XVI. Plan of Care 16.7 A home health agency and the patient ' s physician shall review the plan for skilled care at least once every 60 days or as required by a specific program. A home health agency ' s professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care. (f) The home health agency shall put verbal orders in writing, signed and dated by the individual who took the verbal order. Verbal orders shall be accepted only by personnel authorized to do so by applicable State and federal laws and regulations as well as by the home health agency's policies. All verbal orders shall be counter-signed by the physician. A facsimile order (fax) is acceptable This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Agency failed to have verbal orders signed by the physician for 1 applicable patient in the sample (Patient # 2). Findings include: 1. Per review on 07/13/10 of Patient #2's electronic and hard copy clinical record, a verbal	H1612		8/11/10

Executive Director 8-11-10

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H1612	Continued From page 2 order was not signed by the physician. The verbal order, initiated by the physical therapist on 12/10/09 for physical therapy visits 1-2 times week for 4 weeks, was found in the electronic record; however, a copy countersigned by the physician was not found. Per interview on 7/14/10 at 10:45 AM the Clinical Coordinator confirmed the verbal order was not sent to the physician to be signed.	H1612	3. The Administrator has assigned the MGH responsibility for follow up on verbal orders sent to physicians are signed and returned to internal administrative staff, namely the Administrative Assistant to the Executive Director and/or the Medical Records clerk. The Administrator will monitor the performance of this function on a weekly basis. Patty Andrews; Marie Hoffman MGH 4. The IT staff person and the Administrator will check to make certain that the software is functioning as described above. 5. The Administrator is responsible to ensure that final claims are not submitted to the Medicare Program until all verbal orders have been signed by physicians. The Administrator will review reports of pre-billing reviews on a weekly basis and document that she has done so. H1612 POC accepted 8/19/10 Karen Campo RN	

Executive Director 8.11.10